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John Bowlby at the Tavistock

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Abstract

Bowlby's best known work at the Tavistock Clinic is his foundational research into attachment relationships. This paper describes his other significant contributions, as a clinician interested in family dynamics and the impact of real events in the genesis of childhood anxieties, and as an institution builder in his role in establishing a psychoanalytically based training in Child Psychotherapy oriented towards public health.

Keywords: *Child psychotherapy, post-war developments in the NHS, family therapy, the Tavistock child psychotherapy training*

John Bowlby's role in building institutional structures which fostered clinical creativity is perhaps less well known than his research work which established the foundations of attachment theory. For those who grew up in the context he influenced he was a figure of major importance, and the international reputation of the Tavistock Clinic and of its child psychotherapy training owes him a great debt. His vision of the potential of the Department of Children and Parents at the Tavistock Clinic was pivotal. He had not only a conception of the necessity for work with both children and parents in a child mental health clinic, and imaginative ideas about different ways in which that could be done, but also a picture of multi-disciplinary collaboration which was exemplary. The pre-war child guidance model of parallel work with children and mothers was expanded in several ways. First, the wider context of the children's lives was to be taken account of through attention to the child's school experience and the involvement of fathers in the clinical work. Second, he was part of a small group of psychoanalysts and analytically minded child psychiatrists who believed that a new profession of child psychotherapy was needed. Their argument was that the number of children who required specialized treatment was far too large to be met by current professional resources. The understanding of the child's mind taking shape within child analysis was impressive, and the pool of experienced professionals who would be interested to undertake a further formal training as part of the development of a public health oriented child and family mental health service was of excellent calibre. Hitherto, training had only been available within the narrower context of child analytic training or on an individual *ad hoc* basis.

Bowlby invited Esther Bick, a formidably able child analyst with a strong background in child development, to set up training within the NHS, which the Tavistock Clinic had decided to join, in line with its commitment to a broad conception of the relevance of psychoanalytic ideas to community mental health. It soon became apparent that Bick and Bowlby did not get on at a personal level, and her emphasis on internal factors in children's emotional difficulties was too narrow for his taste. Before she moved on, Bick was able to establish training which combined naturalistic infant observation, the academic study of child development and of psychoanalytic theory, and closely supervised clinical work with children and adolescents alongside personal analysis. Martha Harris, with whom Bowlby had a warm rapport, was Bick's successor. The Bowlby/Harris duo represented different emphases but they worked together well, and their students understood that these disparate elements were a necessary part of their training. There was some space for individuals to go more in one or the other direction, and some of the early child psychotherapy trainees like Mary Boston and Dina Rosenbluth worked closely in Bowlby's research team with James Robertson.

As well as making this new training possible within the Tavistock Clinic, Bowlby contributed to the creation of the Association of Child Psychotherapists, which linked three trainings together: the one Anna Freud had started at a similar time in the Hampstead Clinic, the Tavistock Clinic training, and a third led by Margaret Loewenfeld, located in the Institute of Child Psychology. Bowlby's political experience and wisdom was needed to protect the new baby of child psychotherapy within a complex of institutional interest which could have throttled it; the Tavistock Clinic itself was dominated by adult psychoanalysis, and work with children was seen as second-class at that time. The Institute of Psychoanalysis, on some of whose members' support the trainings had to be built to provide the personal analysis for students and the clinical supervision of cases, was ambivalent about training outside its own boundaries; the idea of non-medical practitioners taking on the intensive treatment of seriously disturbed children and adolescents and acquiring independent expertise and status was by no means universally accepted. Bowlby's loyalty to the project remained solid and meant an enormous amount to this tiny profession as it emerged.

Bowlby was part of a post-war generation who believed they could change things in quite profound ways for children and families, that they had a knowledge base to do this appropriately, and that research could and would expand our understanding of human relations further. It was a time of hopefulness about fundamental change. At the Tavistock Clinic the caveats about the negative forces in human beings which could unleash a world war and attack and destroy creativity were always part of the culture; the Kleinian tradition within British psychoanalysis had taken up some of the more pessimistic strands of Freud's thought, and ideas about the origins, nature, and forms of human destructiveness were much discussed. Bowlby's optimism and radicalism must have represented the positive pole in this small but intense hothouse. The people he disagreed with often shared vital elements in his perspective, and alliances could thus be sustained and work got done. Analytically minded clinicians and researchers were all outsiders in some ways; the dominant paradigm in psychiatry was certainly not either psychoanalysis or the beginnings of attachment theory and the academic world remained hostile to all this with some small exceptions. Bowlby's efforts to make a link for the Tavistock Clinic with London University were rebuffed, making it clear that this was an organization that had to stay on the margin, tolerated by the Establishment in gadfly mode. How strange this now seems when we look at the international scope of attachment theory and research.

Bowlby's clinical thinking also deserves our attention. There are a number of significant contributions, but two retain a particular freshness. The first was a paper published in 1949: "The study and reduction of group tensions in the family." This is how it started:

Child guidance workers all over the world have come to recognize more and more clearly that the overt problem which is brought to the Clinic in the person of the child is not the real problem; the problem which as a rule we need to solve is the tension between all the different members of the family (Bowlby, 1949).

What he goes on to demonstrate is his development of a model of experimental family therapy combined with individual work with family members, both child and parents. So here we have Bowlby the psychoanalytic family therapist, drawing on the theories of Wilfred Bion and Elliott Jaques about group functioning to adapt traditional models of parallel work with child and parents to one in which the dynamics of the family group can be addressed in joint interviews. In a fascinating final section of the paper, he also explores, in a very optimistic vein, the idea that benign processes in one social context (e.g., in a family helped by a clinical intervention) can influence much beyond the family's boundaries. Children go to school, adults work in the wider world, and so on, and their better states of mind will influence these contexts too, he argues. It is useful to keep this in mind when as clinicians we worry about how we can ever do enough to make a difference in the context of increasing expectations, evidence of higher levels of distress, and constraints in resources; one good piece of work can, Bowlby is pointing out, have a positive impact in complex ways. This paper is an instance of Bowlby's capacity to link ideas from different intellectual origins in creative ways. His approach to work with families became one vital strand in the Tavistock Clinic's development of family therapy. He combined attention to unconscious dynamic factors in the minds of family members, with an exploration of the family system, and indeed much wider systemic influences. The later divergence between systemic and psychoanalytic thinkers was not consistent with Bowlby's convictions.

A second significant contribution is his paper: "Knowing what you are not supposed to know and feeling what you are not supposed to feel" (Bowlby, 1988). The final version of this has a cognitive focus and feel to it, but its broader import was his version of the impact of real traumatic events on children's minds. He never tired of enquiring about what a child might have actually experienced as a crucial element in understanding anxieties and behavioural problems. Although he argued that psychoanalytic therapists were guilty of ignoring real events and overvaluing fantasy, the work of Selma Fraiberg and all that has developed in the field of infant mental health, to take one well-known example, allows us to open up the question of what is included in this category of "real events." The unconscious identifications in a mother's mind are all too real when they have the character of the ghosts in the nursery she described. Similarly, Bion's theory of container and contained drew attention to the importance of the qualities of the container and the disastrous results of the absence of the containment of infantile anxiety on the development of a capacity for thought. I would like to suggest that, although Bowlby took a stance rather critical of analytic thinking and practice, he remained in many ways deeply in tune with its ideas while adopting other forms of description. Making therapeutic contact with a child damaged through massive neglect or projections which have undermined his sense of reality means the therapist getting to know at gut level about feeling driven mad, and the desperate psychological measures taken to protect the self in such circumstances. This is the work that cannot be avoided.

A recent clinical example which exemplifies Bowlby's impact on child psychotherapists comes to mind. The work is with a child with major physical and cognitive defects, and is taking place within his special school. Despite his enormous difficulties in verbal communication, his impulsiveness and aggressive behaviour, and his physical disorganization and frailty, school staff felt there was an inner richness which could be reached by individual therapy. This proved to be the case, as his imaginative therapist found ways to perceive the rhythmic qualities he was reaching for, which could give some more shape and meaning to his life. As their conversational reciprocity began to grow, this little boy's awareness of his enormous and tragic limitations also came into focus. Alongside this was the evidence in the therapy of an internal maternal object which turned a blind eye to the reality of the child's damaged state, and work being done by a colleague with the mother in fact confirmed that denial, idealization, and infantilization characterized her relationship with her son. Here was a child using his therapist to help him to know what he was not being allowed to know within the family setting. The freedom to have his own experience which therapy provided seemed a vital step in his developing much greater verbal capacities.

My own experience of Bowlby's contributions to multi-disciplinary case conferences underlines another characteristic of his clinical approach. The patient I was presenting was a highly disturbed 6-year-old who had a grim early history, including major prematurity and a hospital admission without her mother's presence at 12-months-old aimed at forced weaning, in her mother's recollection, during which she cracked her skull by head-banging. The family history was also very distressing since her father grew up in Poland during the war years. In her sessions with me, the extremity of her mental state was expressed in unmistakably primitive terms. She was preoccupied with the dread of a destroyed inner world which could not be repaired and by the absence of protective good objects and their replacement by vengeful persecutors. I was astounded by the material which, week by week, seemed to demonstrate the accuracy of some of Melanie Klein's theories about early infantile life. At the same time, it put me in touch with how intergenerational trauma can impact on development, that is how powerful unconscious projections by parents can shape a child's mind. One example that stunned me was when my patient referred to the Auschwitz furnaces in her play; that was where bad babies were thrown, she said.

At the end of my clinical presentation, Dr. Bowlby said that this was the kind of child for whom intensive psychotherapy was an absolute requirement. He suggested that there were undoubtedly elements of brain damage in my patient, and I think he was right about this, but that this was all the more reason for providing this treatment for her, to give her the best possible chance of developing her potential and making life for her and her family more bearable. As I was fully aware of the risk of a Klein vs. Bowlby scrap over this case among the senior staff in the department, I was impressed by his dual kindness, to the patient and to me as a youthful child psychotherapy trainee. I think he would be pleased at the way in which child psychotherapists have proved themselves committed to work with groups of patients whose life chances are severely compromised. Work with deprived, neglected, and maltreated children, with refugees, and with children with learning disabilities, including autism, are some of the everyday specialities of the profession he helped to bring into being. Bowlby noted that different therapeutic modalities sometimes converge and would probably have liked the more pluralistic clinical context we live in, but I think he would never have underestimated the difficulty of the work to be done and would probably have been politely sceptical about today's plethora of quick-fix remedies.

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